GEORGIA STATE BOARD OF NURSING HOME ADMINISTRATORS
237 Coliseum Drive
Macon, Georgia 31217-3858
(478) 207-2440 (Telephone)
http://sos.ga.gov/plb/nursinghome

DOCUMENTATION OF COMPLETION OF ADMINISTRATOR-IN-TRAINING PROGRAM

PART I - TO BE COMPLETED BY APPLICANT (ADMINISTRATOR-IN-TRAINING)

NAME: _____
Last First Middle Maiden

HOME ADDRESS: _____
Street Address City State Zip Code

PART II - TO BE COMPLETED BY PRECEPTOR

NAME: _____
First Last Middle Maiden

EXACT NAME(S) OF NURSING HOME(S):

1.

2.

3.

LOCATION(S) WHERE AIT PROGRAM WAS SERVED:

1. _____
Street Address City State Zip Code

2. _____
Street Address City State Zip Code

3. _____
Street Address City State Zip Code

DATE(S) OF AIT PROGRAM:	FROM:	TO:

PART III - PRECEPTOR'S EVALUATION OF APPLICANT'S ABILITY

INSTRUCTIONS:

- Please evaluate the above-named Administrator-in-Training's present ability to function in a Nursing Home. See Board Rule Chapter 393-4-.02(2).
- Use a separate sheet, as necessary, and identify the AIT.

PRECEPTOR'S EVALUATION:

❒Yes ❒ No Do you recommend that the Applicant's period as an administrator-in-training be approved by the Board as meeting the requirements for licensure? If "No," please explain and attach relevant documentation.

PART IV - SIGNATURES

APPLICANT:

By my signature below, I affirm that I have discussed this report with the Preceptor of my Administrator-in-Training Program.

_____ _____
Date Signature of Applicant

PRECEPTOR:

By my signature below, I affirm that I have discussed this report with the above-named Applicant for licensure as a Nursing Home Administrator.

_____ _____
Date Signature of Preceptor

Sworn to and subscribed before me this

_____ day of _____, 20____.

_____
Notary Public
My Commission Expires_____ **NOTARY SEAL**